THE TREATMENT OF SEX OFFENDERS

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THE subject for discussion to-night is "The Treatment of Sex Offenders". I will open the discussion by providing some frames of reference and making some suggestions which will remind us of the problems confronting us in the matter.

The importance of the subject itself derives from the frequency of such offences in the community and the consequent effects on the victims, and from difficulties of managing the offenders in the same way as other delinquents. I understand the Society discussed this matter some ten years ago, and made recommendations to the appropriate authorities, but what the recommendations were I do not know. Psychiatry has changed in the last ten years, and we may now arrive at a slightly different outlook.

First, my qualifications as an expert in this field are not distinctive. My knowledge of law is acquired from psychiatric books; and over the last fifteen years or so, although dealing frequently with sex offenders, I have only dealt with them at the rate of perhaps two or three at a time. I do not say this as an apology, but because I think it is important for you to realize that it is unlikely that anybody in this community has made any real specialization in this field. That, I think, is one of our major difficulties—as will appear later.

It will be helpful to define the field.

Treatment. By treatment I propose to include all forms of disposal, management or psychotherapy applied to offenders.

Table 1.—Treatment

Hanging
Flogging
Imprisonment, with or without
(a) Rehabilitation efforts
(b) Psychotherapy

Institutional care
- (a) Borstal
- (b) "Approved" school
- (c) Etc.

Mental hospital

Probation, with or without
- (a) Suspended sentence
- (b) Conditions

Physical medical treatments
- (a) Gland therapy
- (b) Castration
- (c) Shock therapy

Psychotherapy
- (a) General counselling
- (b) Suggestion
- (c) Persuasion
- (d) Analytic methods
- (e) Psychoanalysis

Using this definition, our list begins with hanging and finishes with psychoanalysis. It is sometimes held that we should distinguish sharply between all these forms of treatment. Perhaps it would be fair to separate hanging from the rest, but I do not think we should separate imprisonment from psychotherapy. Imprisonment should be regarded as a form of psychotherapy.

What are *sex offences*? The second table shows a list of sex offences under English law, taken from East (1):

Table 2.—Types of Offence (Legal)

Unnatural offences
- (a) with animals
- (b) with man, per anum

Attempts to commit unnatural offences
Indecency with males
Rape
Carnal knowledge of idiot, etc.
Indecent assaults on females
Defilement of young females
Incest
Procuration
Abduction
Bigamy
Prostitution
Indecent exposure

There are, of course, many other sexual offences; not an uncommon one is the ringing up of telephone assistants and speaking obscene words to them. Obscene libel may also be considered a sexual offence. (Laughter.)

One matter of interest is that adultery, which is not included here, is an offence in many countries.

The frequency of these offences is rather difficult to estimate; it is important for us to realize that it *is* difficult, and just *why* it is difficult. There does not seem to be any easy way of finding out how common these offences are in the community. Probably the only way to find out in Victoria would be to go through the lists of the different courts, from the Court of Petty Sessions upwards, and count them, and it could be a considerable task. However, it will give us some idea of the relative proportion of these offences if I show you some figures from England for the year 1938, of convictions recorded.

Table 3.—Frequency of Offences (England, 1938)

Unnatural offences	58	
Attempts thereat	76	
Indecency with males	366	
Total homosexual		500
Rape	40	
Indecent assault on females	115	
Defilement of girls under sixteen	210	
Indecent assault on girls under sixteen	657	
Total assaults on females		1022
Indecent exposure	1574	
Prostitution	3192	

To translate these figures to Australian conditions one might well divide them by five, assuming the proportion is somewhat similar here, making an estimated total of 100 homosexuals, 200 assaults on females of various kinds, and 300 indecent exposures. As you see, I am beginning to divide these offences into three classes and this trend will run right through my discussion.

Table 4.—Guessed Frequency in Australia

	Offenders	Not charged
Homosexual	100	10,000 ?
Assaults	200	5,000 ?
Indecent exposure	300	3,000 ?

The first column of the table indicates the division by five; but how many of these people are there in the community? I here made a wild guess at the number of homosexuals in Australia; of all the homosexuals I have seen in psychiatric practice, I suppose more than a hundred to one of them have never been charged but have actually committed technical offences of various kinds. Also, the number of assaults on females is very much larger than the number convicted or brought to trial. It is very common in psychiatric practice to see the results of such assaults. I suppose that in my hospital out-patients' clinic at the present time there would be four or five women who have been raped, the offenders never having been detected, and it has not been possible to make any attempt to detect the offender. I again made a wild guess here which may be open to question. In the case of indecent exposures we are on firmer ground. Most cases I have seen have told me they have exposed themselves many times prior to the occasion when they were detected.

This magnitude makes the problem extremely important, not only from a social and legal point of view, but also from the viewpoint of prevention.

I propose now to make a reclassification of offences from the psychological point of view.

The first point to note is that sex offences cannot be equated with sexual abnormality; many sex offences indicate a fairly normal form of sex expression, and many sexual abnormalities are not punishable by law. Most common in the latter group are female homosexuality, many kinds of aberrant behaviour connected with heterosexual expression and a good deal of homosexuality which is practised but only rarely brought to trial. Secondly, there are a number of other offences committed —many cases of murder, arson, theft, etc., which have a sexual importance to the offender. These are not included in our figures of "sexual offences".

Table 5.—Types of Offence (Psychological)

Sexually deviant:
- Animals
- Male homosexuality
- Indecent exposure
- Infantosexuality

Assaults with
(a) normal sexual object
(b) deviant sexual object

Excessive sexual impulse
Some cases of rape
Some cases of defilement of young persons
Prostitution

On this table we have our main psychological divisions. This type of classification could be extended to a point of fantastic complication, but I do not propose to go into the matter any further here. I shall have some remarks to make later about more definite diagnosis, but only in relation to treatment. The classification shown here is broadly Freudian, according to orthodox psycho-analytic classification, but using different terminology. Freud refers to my second group as "aberrations with regard to the sexual aim", and includes masochism and fetishism. My classification of "assault" is mainly concerned with sadism. The third group includes the heterogeneous "borderline" cases. I do not propose to deal with prostitution at all to-night, but have left it in the table to complete the picture.

In placing assaults or sadistic perversions in a separate class from the deviant I am conscious of the distinction in causation here. Many crimes of violence, sexual and non-sexual, are due to character defects and environmental influences, which takes us far outside the field of sexual pathology. We may note that a knowledge of wrongdoing is not required to establish guilt in many of these cases.

In considering the psychological traits further, in looking at the individual offender, we have to take into account various things—

Table 6.—Psychological Traits to be Considered

Deviant sexuality
Psychopathic tendencies
Criminal tendencies
Aggressiveness
Temporary lack of control
Compulsions
etc.

Here we have a list of some of the psychological traits which need to be considered in our examination of the sexual offender. General aggressiveness is an important question which comes up

in many of these cases. The amount of expressed aggression varies in people to a very great extent. There are people who show very little aggression and some who show a considerable amount, and of the latter group many turn their aggression into useful and normal channels. Sometimes this sort of person becomes involved in delinquency and it becomes necessary to consider the aggression as a separate trait with a history and development of its own. The "etc." in the table I leave in because there are a number of examples in this large field of neurotic patients of all kinds; the compulsive is only one type, and includes many people who commit offences and who have a definite unconscious wish to be found guilty. They commit crimes partly so as to be found guilty and punished. That is part of their neurosis.

Having cleared the ground we come to the subject of the discussion, *treatment*. In using the word treatment in its widest sense we must realize that we have a duty to the community and that this must be the first duty; it is clearly the responsibility of the judge, but not only is it his responsibility, but that of all citizens in the community. Sometimes it would appear from the actions of certain people in court—the defending counsel and witnesses—that they overlook this fact; this is the main reason why there has been a good deal of discredit reflected on the psychological approach to the treatment of delinquents. The psychiatrist, of course, is not a judge, but is there to assist the judge, not to assist the prosecution or the defence. It is clearly not his primary duty to assist either side, not only for psychological but for economic reasons.

To treat an offender one must first make a diagnosis and *then* make a prognosis; that is to say, *before* treatment we must consider what might happen in the future. We have to make some sort of prediction as to what will happen if there is no treatment, and what will happen with different kinds of treatment—imprisonment, psychotherapy, etc. It is important to realize that in making a prognosis we simply state a probability, and this has a certain value which can be assessed. I have been asked in court whether I think the accused will commit the offence again if he is released on a bond. The answer to that is often not "Yes" or "No", but should be an estimate of probability. No judge has ever said to me: "If you were a betting man what odds would you lay on this man doing it again?" If one makes the reply: "I have weighed this case up and think

it will be safe to put him on a bond", one might be implying that the balance of the factors are slightly in this man's favour—say 51 chances to 49 that he will be all right. The same statement might mean that there is a 99 to 1 chance. There is far too little quantitative assessment of probability, assessment of prediction, in the consideration of what may happen to such cases.

The main point to make about prognosis is that it is useless to attempt to assess it before making a thorough diagnosis, and that, of course, is a traditional statement from a medical man. One must use a considerable amount of time in making a diagnosis in any case. It involves taking a history of the case, collecting information from records, the giving of psychological tests, and perhaps time involved in special analytic methods of finding out more about the personality of the patient. There are the usual methods of psychiatry, but they are not, as you will realize, often applied thoroughly in criminal cases. The time which one has available to make such investigation is, of course, limited, and one is quite often precluded from access to many records. But here a practical point I would like to make is, that when you have taken a history and have other information from other persons, and from records, and you have used methods of psychological testing which you think should be done, then, and only then, you have something on which to make a prediction.

The usual method of attack on psychiatric evidence in the courts, as far as I know, is to say—"But you only make this prediction on the grounds of what this man told you; he may have been a liar." Usually, however, as a matter of practice, psychiatrists, as well as judges, are pretty good at detecting liars.

One's difficulties arise from the complexity of the data presented, or, alternatively, the lack of it. Many won't tell you very much, and where psychiatrists fail in their judgment is not because people are liars, but because the subject is intrinsically difficult, or because they have not obtained all the data that might be available, or both.

In considering diagnosis there are two main things: first, deviant sexuality and its history; and secondly, delinquent tendencies generally. I do not think we have time to go into the psychology of deviant sexuality, but I would allude to the fact that there is quite a lot of relevant knowledge about the development of sexual instincts.

With regard to the delinquent tendency, here we need to assess not only whether this man had an impulse to do something which is an offence, but what sort of control he has over impulsiveness. We have to study the impulse and its control, because treatment may be directed at either or both of those two things. Treatment can quite often do nothing about the basic causes but may do something about controlling the impulse. This fact is sometimes not clearly realized by those who suggest that all sex offenders should be treated by psychotherapy, implying they can all be cured. Many cannot be cured but we can help them, perhaps, to control their impulses.

Table 7.—Psychiatric Diagnosis

No abnormality
Mental defect
Lack of control from
  (a) Alcohol
  (b) Cerebral disorder
  (c) Epilepsy
  (d) etc.
Psychopathic personality
Psychosis
Psychoneurosis

This indicates the various forms of traditional psychiatric diagnosis which can be made. Mental defective cases usually have insufficient control over their impulsiveness to keep out of trouble. Lack of control from alcohol, cerebral disorders, arterio-sclerosis, epilepsy, is a purely medical question. Psychopathic personality is another diagnosis commonly made. The psychopaths as a group sometimes tend to be the waste paper basket collection in psychiatry. We have had considerable argument on what is the definition of a psychopath, but the term broadly refers to people grossly abnormal in their impulsiveness but of normal intelligence. Psychosis refers to the types of disorder which may result in insanity; and psychoneurosis refers to disorders arising from anxiety or maladjustment.

Many cases of sex offenders have a long history of other offences, such as prior convictions for house-breaking, rape, serious assault and other things. These offenders are the most difficult to deal with, and little is known of their psychopathology.

Table 8.—Main Types of Offenders

Assault with heterosexual aim
- Criminals
- Psychopaths
- Alcoholics
- No abnormality

Homosexual
- Psychopathics
- Psychoneurosis (not remediable)
- Psychoneurosis (remediable)
- Psychosis

Indecent exposure
- Psychoneurosis
- Psychoneurotic symptom unmasked by alcohol

Here we classify the offenders and not the offences, the types of offenders committing the three main types of offence.

In considering the diagnosis of any single case one must keep in mind a knowledge of the individual's sexual pathology, but a knowledge of this is not sufficient to say that you can cure him. We know a good deal about the development of the sexual instincts and deviations, but we are confronted with many men we cannot cure because there is something about them we do not know.

I come now to prognosis. We need first to consider how much data we have, and how much we have not, before we can get any idea of the certainty of a prognosis; this is the point which is so difficult in practice: not the technical psychological knowledge but the assessment of the certainty with which you can make the prognosis. Usually we tend to infer prognosis from the class of disorder; e.g., psychotics should be sent to a mental hospital; psychopathics we cannot treat very well, and if certain things are *found* we cannot do anything useful for them, and so on.

Psychiatrists work generally to get some sort of a *label* to put on the patient, and then go on to find out what sort of specific things are in the personality of the patient, what temperament, what intelligence, and so on. We consider not only the disorder but the field in which it occurs. This is a particular difficulty of psychiatry as opposed to other forms of medicine, and in psychiatry we are continually faced with this double complication. We have to consider also causative factors. If we have

knowledge of definite causative factors we can, perhaps, place the person in such an environment that these offences will not happen again. We must also take into account the positive qualities of a person, not only assessing what is wrong, but what is right with the patient, and the will to cure in the patient himself. All psychiatrists will agree that this latter is the most important thing in psychoneurotics with regard to their remediability.

This "will to cure" is something which seems to be associated with insight into the fact that there is something wrong, insight into where it is wrong and what sort of things lead to the maladjustment. The truthfulness of the patient is another thing which tends to give the impression that there is a good "will to cure". Many of these people plead amnesia. That is a special problem; but in general if a patient has a true amnesia for such crimes he is seriously ill, and if he is lying he is not a good subject for treatment. Generally, patients with amnesia for sexual crimes are bad subjects for psychological treatment.

Now all these things take time. First we are limited by the factor of time, and secondly we are limited by the attitude of the defence. Normally the expert witness is called either by the defence or the prosecution, and what is going on in court may be something which is entirely a legal matter. It may be concerned with legal technicalities, and, in fact, one's diagnosis is often considerably restricted by the attitude of the defence. Even if one has made a satisfactory diagnosis, the defence may not like it, and cases have been known where one psychiatrist's opinion has not been taken and another psychiatrist's opinion has been sought until one satisfactory has been found. (Laughter.)

One is also limited by the "unwilling patient", the patient who says "I did not do it." He is frightened to say he did it. He does not want to see a psychiatrist because it may prejudice his case and something may come out in court which might lead to his being found guilty, and naturally he hopes to be found not guilty. There our prognosis is limited by our diagnosis.

One's prognosis is also limited by one's own knowledge and experience. One can accumulate certain experience oneself, but there are no figures published of the frequency of such cases or the effects of treatment. There is a sweeping statement in the report of Penal Establishments, Etc., for 1946, where it says:

"So far as can be found, no evidence has yet been produced that psychiatric treatment or treatment by purely medical means has yet produced worthwhile results."

That sort of vague statement unsupported by figures is the rule. This particular statement is, of course, untrue (2). The judge is the man who decides treatment. The judge in sentencing a man can, if he wishes, use the sentence as a sort of retaliation, as a deterrent to others, or with some idea of treating the man, or protecting the community from him. I think we are all agreed that the time the judge is able to give to sentencing is far too short to enable him to do it properly, to enable him to assess all the factors and make predictions and decide what is the best thing to do. Furthermore, when the patient gets to prison he is faced with the fact that no rehabilitation effort is made for him. If an offender gets to prison there is no psychotherapy available because there is not sufficient time given by any one person who is competent to do this. If he is not sent to prison, there are no probation officers to look after him and psychological treatment is negligible. In England there is a voluntary clinic—the Institute for the Scientific Treatment of Delinquency, where I worked for a time, and it takes cases referred by the courts, by probation officers, and cases who come of their own accord. These cases are selected for treatment and about half of them are "cured".

Psychotherapy, if it can be obtained, means that it has to be obtained privately; it is expensive and it must sometimes take the form of psychoanalysis, which is time-consuming, requiring a patient to attend 100 or 200 hours with the analyst at a certain price per hour, which he is usually unable to afford. There are other kinds of psychotherapy aimed at control of the impulse which are cheaper and more easily available. These are, of course, satisfactory in selected cases, but not in others. Here we have no research that I can quote of the effects of treatment. You are probably familiar with the report of East and Hubert (2), on the effect of treatment in prisons in England made some years ago, but no definite quantitative conclusions were drawn other than the fact that some people could be treated successfully, but a lot could not be. I think there should be considerable effort made to do some statistical research on the effects of treatment on these cases.

What actually happens? I think half the homosexuals, if properly selected, can be helped sufficiently to keep them out of future trouble, and more than half of the indecent exposure cases can also be helped; of the assaults, very few; and amongst

all cases very few of those with criminal records of other kinds could be treated by ordinary methods.

In treatment one should also discuss prevention, but I do not feel competent to expound on the matter. I could make some remarks about bringing up children and Child Guidance Clinics, but what particular application it has to this problem I do not know. Prevention, in our present state of knowledge, involves the general principles of prevention of psychiatric disorders, and of delinquency.

I have now defined the field, alluded to a number of problems, and implied a number of reforms that might be made.

Table 9.—Reforms

1. Legal
2. Diagnostic clinic
3. Penal, so as to provide
   - (a) for long sentences
   - (b) rehabilitation
   - (c) psychotherapy
4. Public psychotherapeutic clinic for
   - (a) victims
   - (b) treatment of selected sex offenders
5. Research into follow-up of offenders
6. Wide application of the principles of mental hygiene in the community
7. Etc.

Legal reforms could be directed into two ways. The reform of laws relating to homosexuality, for instance, is long overdue. The absurd methods of procedure in the courts prevent the expert from being any real use to the judge. The expert should be employed by the court, and not by either side. He should preferably be a representative of a Diagnostic Clinic. A Diagnostic Clinic would not be a great expense; it would cost about £5,000 a year and it could do a tremendous amount of good work in these and other criminal cases—the sort of work being done or touched upon by the Government Medical Officer and his assistant.

The next reforms are penal reforms. There is a common view that there should be long sentences for many of these people when they are not remediable by direct treatment on probation, and that these long sentences should be indeterminate. If you are going to have indeterminate sentences for

any sort of criminals and sex offenders you require people who can competently decide on the length of sentence, including experts in psychiatry, and you also imply, I think, that there should be a real attempt at rehabilitation with psychotherapy within the penal establishment.

The next reform suggested is a Public Psychotherapeutic Clinic. This should be established for the victims of these offences; all psychiatrists know about these victims of sexual assault. It would be a wise step if the victim were dealt with at the time of the trial so that some responsible body saw to it that treatment was available. Treatment for selected sex offenders is required, research on offenders, follow-ups, and consideration of other reforms which might arise out of the wider application of the principles of mental hygiene in the community.

I think I had better stop here. From what I have said I believe there is a place for the psychiatrist expert in this field. I hope I will not be accused of saying that the judge should be a psychiatrist, because judicial functions have to take other things into account, far beyond the domain of psychiatry. Further, I have not suggested that all sex offenders are curable. They are not, but perhaps many more are capable of satisfactory social conduct than we realize because we have not tried hard enough to readjust them, and the same could be said of all types of criminals. I believe the most pressing reform to be in the establishment of proper scientific diagnostic procedure in all criminal cases.

I will conclude with a quotation from an American psychiatrist (4), with which I agree:

"Psychiatry may properly be used to help the law but in its adolescence must not displace the law nor arrogate unreviewable infallibility to itself. In our culture the law is still, and we think properly, the last word in dealing with human conduct and misconduct. It is the last word, but it need not be the sole word."

References

(1) East, W. N., in *Mental Abnormality and Crime,* Vol. II of *English Studies in Criminal Science.* Macmillan, 1944.
(2) East, W. N., and Hubert, W. H. de B., *The Psychological Treatment of Crime.* H.M.S.O., 1939.
(3) Quoted by East (1), p. 180.
(4) Mannheim, H., *Criminal Justice and Social Reconstruction.* Kegan Paul, 1946.